

**GROUP ACTIVITIES: Individual Participant Direct Service Data Collection Tool**  
(May use if AB99 information is already collected)

**Program/Group Name:** \_\_\_\_\_ (optional) **Activity Location Name:** \_\_\_\_\_

**Date Information:** Single or Start Date (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End Date (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Number of occurrences:** \_\_\_\_\_ **Average duration:** \_\_\_\_\_ ☐ hours **OR** ☐ minutes **OR** ☐ Not applicable

Enter **ONE** modality code in the box: 

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<b>Modality</b> <b>00</b> Not specified <b>Codes:</b> <b>01</b> Case management <b>02</b> Home visit <b>03</b> Mobile service	<b>04</b> In-person consultation/service <b>05</b> Support group session <b>06</b> Class/workshop <b>07</b> Public/community event	<b>08</b> Phone consultation <b>09</b> Mailing/distribution of materials <b>99</b> Other
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**Please mark (X) ALL applicable activities associated with the modality entered above.**

**Result 1: Improved Family Functioning (Family Support, Education and Services)**

- |  |  |
|--|--|
| <input type="checkbox"/> Behavioral, Substance Abuse, and Mental Health Services<br><input type="checkbox"/> Substance abuse treatment/screening<br><input type="checkbox"/> Mental health/Behavioral assessment<br><input type="checkbox"/> Behavioral aides<br><input type="checkbox"/> Play therapy<br><input type="checkbox"/> Parent-child intervention<br><input type="checkbox"/> Other psychological counseling<br><input type="checkbox"/> Social skills training<br><input type="checkbox"/> Psychiatric/medication services<br><input type="checkbox"/> Behavioral consultation<br><input type="checkbox"/> Individual behavior plan<br><input type="checkbox"/> Other therapy<br><input type="checkbox"/> Adult Education and Literacy for Parents<br><input type="checkbox"/> Adult literacy programs<br><input type="checkbox"/> Job training/citizenship/other adult education<br><input type="checkbox"/> Community Resource and Referral<br><input type="checkbox"/> Special education service referral | <input type="checkbox"/> Distribution of Kit for New Parents<br><input type="checkbox"/> Family Literacy Programs<br><input type="checkbox"/> Raising a Reader<br><input type="checkbox"/> Provision of Basic Family Needs (Food, Clothes, Housing)<br><input type="checkbox"/> Provision of food, clothes, emergency funds, housing, or other basic needs<br><input type="checkbox"/> Enrollment/assistance with TANF, WIC, Food Stamps, or food program<br><input type="checkbox"/> Transportation services or voucher<br><input type="checkbox"/> Targeted Intensive Parent Support Services<br><input type="checkbox"/> Respite care<br><input type="checkbox"/> Parent conference<br><input type="checkbox"/> General Parenting Education Programs<br><input type="checkbox"/> Other Family Functioning Support Services<br><input type="checkbox"/> Family planning<br><input type="checkbox"/> Service coordination |
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**Result 2: Improved Child Development (Child Development Services)**

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| <input type="checkbox"/> Preschool for 3 and 4 Year Olds<br><input type="checkbox"/> Enhanced art curriculum<br><input type="checkbox"/> Enhanced science curriculum<br><input type="checkbox"/> Comprehensive Screening and Assessments<br><input type="checkbox"/> Developmental screening – SNP protocol<br><input type="checkbox"/> Speech and language assessment<br><input type="checkbox"/> Other screening or assessment<br><input type="checkbox"/> PFA - ASQ<br><input type="checkbox"/> PFA – DRDP<br><input type="checkbox"/> Targeted Intensive Intervention for Identified Special Needs<br><input type="checkbox"/> Consultation on speech and language<br><input type="checkbox"/> Group speech and language therapy<br><input type="checkbox"/> Individual speech and language therapy<br><input type="checkbox"/> Socialization group<br><input type="checkbox"/> Specialized movement class<br><input type="checkbox"/> Inclusive recreation program<br><input type="checkbox"/> Integrated play group<br><input type="checkbox"/> Buddy program<br><input type="checkbox"/> Social-emotional curriculum | <input type="checkbox"/> Discrete trial training or other behavioral teaching program<br><input type="checkbox"/> Individual learning plan (ILP)<br><input type="checkbox"/> Initial IEP / IFSP<br><input type="checkbox"/> Update of IEP / IFSP<br><input type="checkbox"/> Early Education Programs for Children (Other than School Readiness and Preschool for 3 and/or 4 year olds)<br><input type="checkbox"/> Recreational/physical activities for children alone or together with parents<br><input type="checkbox"/> ECE*/child care subsidies or vouchers<br><input type="checkbox"/> ECE*/child care resources and referral<br><input type="checkbox"/> Kindergarten Transition Services<br><input type="checkbox"/> Other Child Development Services |
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\*ECE = Early care and education

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**Result 3: Improved Health (Health Education and Services)**

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| <input type="checkbox"/> Breastfeeding Assistance   | <input type="checkbox"/> Safety Education and Intentional and Unintentional Injury Prevention |
| <input type="checkbox"/> Nutrition and Fitness  | <input type="checkbox"/> Safety education and injury/violence prevention                      |
| <input type="checkbox"/> Other Health Education   | <input type="checkbox"/> Car seat distribution  |
| <input type="checkbox"/> Health Access  | <input type="checkbox"/> Specialty Medical Services   |
| <input type="checkbox"/> Home Visitation for Newborns                                     | <input type="checkbox"/> Audiology services   |
| <input type="checkbox"/> Oral Health  | <input type="checkbox"/> Vision services  |
| <input type="checkbox"/> Dental screening   | <input type="checkbox"/> Physical therapy   |
| <input type="checkbox"/> Dental treatment   | <input type="checkbox"/> Occupational therapy   |
| <input type="checkbox"/> Oral health education  | <input type="checkbox"/> Assistive technology services  |
| <input type="checkbox"/> Prenatal Care  | <input type="checkbox"/> Medical evaluation for diagnosis                                     |
| <input type="checkbox"/> Primary Care Services (Immunizations and/or Well-Child Checkups) | <input type="checkbox"/> Nursing services   |
| <input type="checkbox"/> General health screening   | <input type="checkbox"/> Other health services  |
| <input type="checkbox"/> Vision screening   | <input type="checkbox"/> Tobacco Cessation Education and Treatment                            |
| <input type="checkbox"/> Hearing screening  | <input type="checkbox"/> Other Health Services  |
| <input type="checkbox"/> Other screening  |   |
| <input type="checkbox"/> Immunizations  |   |
| <input type="checkbox"/> Well-baby or well-child checkups                                 |   |

**Participant Roster**

First name	Last name	Birth date (mm/dd/yyyy)	Total service contacts (days of service)
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